MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11141

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County: HOWARD

City or town: ROUTE 1 NEAR WATERLOO
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Berkeley Co.

City or town: Martinsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R 7 B 1
(If rural, give LOCATION)

2.(a) If veteran, name war: √

3. (a) FULL NAME: Woodrow Russell Barrett

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Bessie Betts Barrett

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1915

8. AGE:

Years	Months	Days	If less than one day
30	-	-	..... hrs. ..... min.

9. Birthplace: W. Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Walter Barrett
13. Birthplace: W Va.

MOTHER
14. Maiden name: Lucy Leight
15. Birthplace: W Va

16. Informant: Bessie B Barrett

Address: R 7 B 1 Martinsburg W Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-2-45 (month) (day) (year)

Cemetery or crematory: Mechanicsville

Location: Martinsburg W Va.

18. Funeral director: F C Hedrickson Hedrickson

Address: Ellicott City Md.

19. Nov. 29, 1945 (Date rec'd by registrar) John B. Langhans Per B.G.L. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/28 1945 at 10 25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/28 1945, to 11/28 1945 and that I last saw h.. l.. in..alive on no date 19.....

Immediate cause of death	DURATION
Fracture of skull at base	instant
Due to being struck by auto	
Due to	
Other conditions multiple fractures and contusions	instant

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 11/28/45

Where did injury occur? Near Waterloo (City or town) Howard (County) Md. (State)

Injured at home, farm, industry, public place (where?) Balto.-Washington Blvd.

Means of injury: Struck by auto Injured at work? no

23. SIGNATURE: George E. Burgtorf M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other

Address: Ellicott City, Md. Date signed 11/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11142

★ Reg. Diat. No. 195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Howard
City or town: Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Le Roy Eugene Conaway

3.(b) Social Security Number:

4. Sex: M | 5. Color or race: W | 6.(a) Single, married, widowed or divorced: married

6.(b) Name of husband or wife: Dora E. Conaway

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 29 1878

8. AGE: Years: 67 | Months: 7 | Days: 0 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Wash. Navy Yard

FATHER 12. Name: Evan J. Conaway

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Josephine Keifer

MOTHER 15. Birthplace: Maryland

16. Informant: Mrs. Dora E. Conaway

Address: Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 1 45 (month) (day) (year)

Cemetery or crematory: Savage

Location: Savage Md.

18. Funeral director: Lloyd Kaiser

Address: Laurel Md.

19. 11/30/45 19 (Date rec'd by registrar) Frank S. Shipley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29th 1945 at 4a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1st 1944 to Nov. 29th 1945 and that I last saw him alive on Nov. 28th 1945

	DURATION
Immediate cause of death: Cerebral Haemorrhage	8 days
Due to: Hypertension	3 yrs.
Due to: Arteri-sclerosis	3 yrs.
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank S. Shipley M.D. M. D. or other

Address: Savage, Md. Date signed: 11/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11143

Reg. Dist. No. 195

1. PLACE OF DEATH:

County: Howard

City or town: Laurel Md R.F.D. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Howard

City or town: Laurel R.F.D. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Wesley Alfred Green

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Sarah E. Green

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 1 1859

8. AGE: Years 85 | Months 10 | Days 5 | If less than one day: hrs. min.

9. Birthplace: Hillsdale Md (Town, county, and state)

10. Usual occupation: Loom Repairer

11. Industry or business: Cotton Mill

FATHER 12. Name: John W. Green

13. Birthplace: ?

MOTHER 14. Maiden name: Elizabeth Ann ?

15. Birthplace: ?

16. Informant: Mrs Viola Whitehead

Address: Laurel Md

17. Burial (Burial, cremation, or Removal. Which?) Date thereof Nov 7-1945 (month) (day) (year)

Cemetery or crematory: Stony Hill

Location: Laurel Md

18. Funeral director: Dewitt Funeral Home

Address: Laurel Md

19. Nov 6 1945 (Date rec'd by registrar) Mamie Linder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 5 1945, at 10 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12 1944, to Nov 5 1945, and that I last saw h... alive on Nov 3 1945

	DURATION
Immediate cause of death: Myocarditis	1 yr
Due to: Chronic nephritis	5 yrs
Due to: Prostate hypertrophy & Obstruction	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Prostate Resected Date of op. 11-4-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. M. Harris M. D. or other

Address: Laurel Date signed 11/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Clarksville, Howard Co.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Clarksville,
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Spicer Hash

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Clinton Hash
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years	Months	Days	If less than one day
28			hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Garnett Spicer
13. Birthplace Va

MOTHER
14. Maiden Name Katherine Brookes.
15. Birthplace Va.

16 (a) Informant Clinton Hash.
(b) Address Ellicott City Md.

17 (a) Burial (b) Date thereof 11-28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Providence
Location Elkridge Md

18 (a) Funeral director F.C. Higinbotham
(b) Address Ellicott City Md

19 (a) Nov. 27, 1945 (b) John B. Lingham
(Date rec'd by registrar) Per B. E. L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1945, at 8 30 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pending
Acute alcoholism. C.W.S.P.
Due to
Other Conditions Cerebral edema.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 11-26-45.

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-e

CERTIFICATE OF DEATH

11145

Reg. Dist. No. 195

1. PLACE OF DEATH:
County Howard
City or town Jessup, Rural (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, institution, or street address where death occurred: Balto.-Wash. Blvd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Howard
City or town Jessup, Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. Balto.-Wash Blvd. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rosa Maynes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Widowed.

6.(b) Name of husband or wife Edgar D.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) September 3, 1885.

8. AGE: Years	Months	Days	If less than one day
60			..... hrs. ..... min.

9. Birthplace Florida (Town, county, and state)
10. Usual occupation Restaurant keeper
11. Industry or business

FATHER
12. Name Jacob Frazier
13. Birthplace Florida

MOTHER
14. Maiden name Grace Frazier
15. Birthplace Florida

16. Informant Mrs Ida Davis
Address 1307 S Street, N.W. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 10, '45 (month) (day) (year)
Cemetery or crematory Arlington Memorial Park,
Location

18. Funeral director Mrs. Katie R. Williams
Address 322 N Schroeder St.

19. ..... 19..... (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 1945, at 2 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1st 1945 to Nov. 8th 1945
and that I last saw her alive on Nov. 7th 1945

Immediate cause of death	DURATION
a. Cardiac Dil.	1 Day
Due to, Congestive Heart Disease —	2 yr.
Due to, hypertension —	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank Shipley, M.D.
M.D. or other
Address Savage, Md. Date signed 11/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

11146 P

Reg. Dist. No. 190

1. PLACE OF DEATH:

County Howard

City or town Elkridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

Church Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Howard

City or town Elkridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. Church Ave

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Matilda Miller

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	widowed

6.(b) Name of husband or wife Eli Miller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 1 1863

8. AGE: Years 82 | Months 10 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace Calvert Co. Md

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Retired

FATHER 12. Name Hawkins

FATHER 13. Birthplace Calvert Co Md

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace "

16. Informant Mattie Simms

Address Church Ave Elkridge Md

17. Burial Date thereof 11/24-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Adeline

Location Calvert County Md

18. Funeral director Isaiah L. Brannon & Son

Address 108 W Montgomery St

19. 11/23 1945 A W Heard

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 17 1945 to Nov 19 1945 and that I last saw h... alive on Nov 19 1945

	DURATION
Immediate cause of death Chr Myocarditis	2 mo
Due to Arteriosclerosis	2 mo
Due to Senile Debility	1 yr
Due to Malnutrition	
Other conditions —	

(Includo pregnancy within 3 months of death)

Major findiogs of operatioos ..... Date of op. .....

Aotopsy results .....

PHYSICIAN: Please underline the caose to which death shoold be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (Cooonty) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. A. Brumbaugh M.D. or other

Address 7609 Main St Elkridge Md Date signed 11-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

11147

1. PLACE OF DEATH

County Howard Md Registration Dist. No. 5-194

Village or City Clarksville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 73 yrs. 5 mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Samuel Cauthen Nichols

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	white	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Beulah S Nichols

6. DATE OF BIRTH (month, day, and year) Jan 26, 1870

7. AGE Years 75 Months 5 Days 5 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. M.D.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) Nov 1st 45

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

FATHER

13. NAME Samuel Cauthen Nichols

14. BIRTHPLACE (city or town) Howard Co (State or country) Miss

MOTHER

15. MAIDEN NAME Mary Jane Hearn

16. BIRTHPLACE (city or town) Md. (State or country)

17. INFORMANT L. Turner Nichols (Address) Clarksville, Md

18. BURIAL, CREMATION, OR REMOVAL Place Highland Md Date 11-5, 1945

19. UNDERTAKER H. C. Higinbothom (Address) Ellicott City, Md

20. FILED 11-2, 1945 L. A. Nichols Per ST N Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Nov (Month) 2 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1945 to Nov 2, 1945

I last saw h— alive on Nov 2, 1945, death is said to have occurred on the date stated above, at 10:30 a.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Cerebral Embolism	

Other **Contributory Causes** of importance:

Name of operation Date of

What test confirmed diegnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. A. Barnes M. D.

(Address) Sykesville, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The **principal cause of death** and related causes of importance were as follows:	Date of onset	The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		**Other contributory causes of importance:**	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-C)

CERTIFICATE OF DEATH

11148 P

Reg. Diat. No. 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred:
Rogers Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rogers Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eva May Rittershofer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Ernest Rittershofer Sr.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 2, 1878

8. AGE: Years	Months	Days	If less than one day
67	7	9	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: Frank Nicholson
13. Birthplace: Penna
MOTHER 14. Maiden name: Christina Ford
15. Birthplace: Maryland
16. Informant: Ernest Rittershofer Sr.
Address: Ellicott City
17. Burial (Burial, cremation, or removal: Which?) Date thereof 11/14/45 (month) (day) (year)
Cemetery or crematory: London Park
Location: 3901 Frederick Rd.
18. Funeral director: Harry V. Witzke
Address: 4101 Edmondson Ave.
19. 11/12 1945 (Date rec'd by registrar) A. W. Heduck Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 11 1945, at 12:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 1934, to November 11, 1945 and that I last saw her alive on November 10, 1945

Immediate cause of death	DURATION
Arterial hypertension.	
Chronic endocarditis (aortic stenosis and insufficiency).	11 yrs.
Due to: Right pleural effusion.	4 wks.
Due to: Myocardial dilitation.	2 wks.
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M B Levin M.D. M. D. or other
Address: 211 W. Monument Street Date signed: Nov. 12, '45

Mr. Levin
211 W Monument St

11149 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

CERTIFICATE OF DEATH

Reg. Dist. No. 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Howard
City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo.
Hospital, institution, or street address where death occurred: 5609 Main st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va — County: Fairfax
City or town: Fairfax
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Eleanor Owens Smith
3. (b) Social Security Number: none

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Dr. William Lee Smith
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May 13 1866

8. AGE: Years 79 — Months 6 — Days 16 — If less than one day ... hrs. ... min.

9. Birthplace: Dunkirk, Calvert Co. Md
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: Dr. John Sparrow Smith
13. Birthplace: Calvert Co. Md

MOTHER
14. Maiden name: Ruth Ellen Owens
15. Birthplace: Westriver Anne Arundel Co Md

16. Informant: Mrs W. Frank Smith
Address: Fairfax, Va.

17. Burial — Date thereof 12-1-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Jarrettsville Cem.
Location: Jarrettsville Md
18. Funeral director: Wm. J. Tickner & Son
Address: North & Penna Ave. Balto Md.

19. 11/30 19... — A.W. Helfrich, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 29 1945, at 12 25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1945, to Nov 29 1945
and that I last saw her alive on Nov 29 1945

Immediate cause of death	DURATION
Carcinoma of liver	6 mo
Due to	
Due to	
Other conditions: Myocarditis with decompensation	1 mo

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: C. Reid Edwards, M. D. or other
Address: 101 W. Read St — Date signed 11/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11150

★ Reg. Dist. No. ~~239~~ 195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Howard
City or town: West Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred: Northwarted
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles C. Talbott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

8.(b) Name of husband or wife: Ida Talbott
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug 1 - 1871

8. AGE: Years	Months	Days	If less than one day
74	3	2	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired Engineer
11. Industry or business
12. FATHER Name: Samuel Talbott
13. FATHER Birthplace: Md
14. MOTHER Maiden name: Louise Lung
15. MOTHER Birthplace: Md
16. Informant: Mrs Ida Talbott
Address: Laurel Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: November 6-45 (month) (day) (year)
Cemetery or crematory: Joy Hill
Location: Laurel Md
19. Funeral director: Lloyd Lauer
Address: Laurel Md
19. November 6 1945 (Date rec'd by registrar) Carrie E. Wachter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 3 19 45 at 12 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 19 34 to Nov 3 19 45
and that I last saw ~~him~~ alive on Nov 3 19 45

Immediate cause of death	DURATION
Myocardial failure	)
Arteriosclerosis	
Due to Chronic Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J M Warren MD
M. D. or other
Address: Laurel Date signed: 11/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

11151

CERTIFICATE OF DEATH Penn

Reg. Diat. No. 4190

1. PLACE OF DEATH:

County Howard

City or town Elkridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred: 5402 Miami Court

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County Luzerne

City or town Moosic Lakes

(If outside city or town limits, write RURAL and give nearest town)

Street No. 201 N. Market St

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME Harry Raymond Yowells

3.(b) Social Security Number 169-14-9069

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary Ann (Eynon) Yowells

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr 17 1891

8. AGE: Years	Months	Days	If less than one day
54	7	13	..... hrs. ..... min.

9. Birthplace Edwardsville Pa.
(Town, county, and state)

10. Usual occupation Miner, Laborer

11. Industry or business Collieries

FATHER 12. Name William Yowells

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Robert E. Yowells

Address 5402 Miami Court Elkridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/29/45 (month) (day) (year)

Cemetery or crematory Denison Cemetery

Location Wilkes Barre, Penna.

18. Funeral director John F. Cowan & Son

Address 901-03 Collins Street

19. 11-29 1945 (Date rec'd by registrar) E. Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1945, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 1945, to Nov 26 1945

and that I last saw h... alive on Nov 26 1945

	DURATION
Immediate cause of death Bronchopneumonia	4 wks
Due to Myocardial degeneration	4 wks.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. R. Armstrong M. D. or other

Address Elkridge Md Date signed 11/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15